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The Node ... where a leaf arises from a stem

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Press Release

GLOBAL ACCESS TO HIV THERAPY TRIPLED IN PAST TWO YEARS, BUT SIGNIFICANT CHALLENGES REMAIN

- 1.3 Million People Now Receiving Treatment in Low- and Middle-Income Countries; Sub-Saharan Africa Leads in Treatment Scale-up
- Lessons Learned in "3 by 5" Should Guide Efforts to Move Towards Universal Access to Treatment by 2010

Geneva - 28 March 2006 - A new report by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) shows that the number of people on HIV antiretroviral treatment (ART) in low- and middle-income countries more than tripled to 1.3 million in December 2005 from 400 000 in December 2003. Charting the final progress of the "3 by 5" strategy to expand access to HIV therapy in the developing world, the report also says that the lessons learned in the last two years provide a foundation for global efforts now underway to provide universal access to HIV treatment by 2010.

Progress in treatment scale-up, while substantial, was less than initially hoped. The report notes, however, that treatment access expanded in every region of the world during the "3 by 5" initiative, with approximately 50 000 additional people beginning ART every month in the past year. Sub-Saharan Africa, the region most severely impacted, led the scale-up effort, with the number of people receiving HIV treatment there increasing more than eight-fold to 810 000 from 100 000 in the two-year period. By the end of 2005, more than half of all people receiving HIV treatment in low- and middle-income countries resided in sub-Saharan Africa, up from one-quarter two years earlier.

In July 2005, the G8 nations endorsed a goal of working with WHO and UNAIDS to develop an essential package of HIV prevention, treatment and care with the aim of moving as close as possible to universal access to treatment by 2010, a target subsequently endorsed by the United Nations General Assembly in September 2005. The new WHO/UNAIDS report outlines a number of steps that must be taken to continue and expand treatment scale up toward achieving this goal.

Substantial Increases in HIV Treatment Access

Countries in every region of the world made substantial gains during the "3 by 5" period in closing the gap between those in need of treatment and those receiving it. The number of public sector treatment sites in low- and middle-income countries increased from fewer than 500 providing ART to more than 5100 operational treatment sites by the end of 2005. A recent survey showed for example that the number of treatment sites in Malawi increased from three in early 2003 to 60, and in Zambia increased from three to more than 110 facilities in just over two years.

Globally, 18 developing countries met the "3 by 5" target of providing treatment to at least half of those in need by the end of 2005, and are now concentrating their efforts on moving towards universal access to treatment. While other countries

fell short of this target, lessons learned in expanding treatment access and overcoming critical weaknesses in health systems are informing new initiatives to further scale-up HIV prevention, treatment and care services. Increased availability of ART averted an estimated 250 000 to 350 000 premature deaths in the developing world in 2005 alone.

Launched by WHO and UNAIDS on World AIDS Day, 1 December 2003, "3 by 5" aimed to provide treatment to 3 million people in low- and middle-income countries by the end of 2005. This ambitious target was based on a 2001 analysis of what could be accomplished with an optimal combination of funding, technical capacity building, health systems strengthening and political will and cooperation. The initiative confirmed that HIV treatment can be delivered effectively in a wide variety of health systems, including those in poor countries and rural settings, and that large-scale ART access is both achievable and increasingly affordable.

Between 2003 and 2005, global expenditure on AIDS increased from US$ 4.7 billion to an estimated US$ 8.3 billion. Significant proportions of this funding were provided by the US President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, TB and Malaria and the World Bank. During the same period, the price of first-line treatment decreased by between 37% and 53%, depending on the regimen used.

Progress: Treatment Access by Region

Between end-2003 and 2005, HIV treatment access expanded in every region of the world. Sub-Saharan Africa and East, South and Southeast Asia, the regions most heavily affected by the epidemic, achieved the most rapid and sustained progress.

- More than 810 000 people in **sub-Saharan Africa**, or 17% of those in need of ART, had accessed treatment by the end of 2005. Well over half the people on ART in the developing world live in this region. This substantial increase in ART availability in sub-Saharan Africa occurred despite considerable regional challenges: the region is home to over 20 of the world's 25 poorest countries, and suffers a shortage of some 1 million professional health workers, with an additional 20 000 trained staff lost each year to emigration.
- **East, South and Southeast Asia** recorded significant gains in ART access from end-2003 (70 000 people) to 2005 (180 000 people), with coverage in the region expanding more than 75% in 2005. Thailand was a major driver of this increase, particularly during 2004 and the first half of 2005.
- **Latin America and the Caribbean**, with more than 315 000 people on ART (up from 210 000 at the end of 2003), is providing treatment to approximately 68% of its population in need - the highest coverage of any region in the developing world. Thirteen countries in this region provide treatment to more than half of the population in need.
- Despite gains in overall numbers on treatment, ART access in low- and middle-income countries in **Eastern Europe, Central Asia, the Middle East and North Africa** was lower than in other regions, with just 21 000 people in Eastern Europe and Central Asia and 4000 in the Middle East and North Africa receiving treatment as compared to 15 000 and 1000 respectively at the end of 2003. Virtually all countries in these regions are experiencing low-level epidemics that involve difficult-to-reach populations such as injecting drug users (IDUs) and sex workers.

Reaching Women, Children and Vulnerable Populations

While the new report found no systematic bias against women in ART access, rates of coverage for women varied. In some countries, more women receive treatment; in others, more men. One notable area of concern is access to therapy to prevent mother-to-child HIV transmission, which remains unacceptably low. Between 2003 and 2005, fewer than 10% of HIV-positive pregnant women received antiretroviral prophylaxis before or during childbirth. As a result, 1800 infants were born with HIV every day. Each year, over 570 000 children under the age of 15 die of AIDS, most having acquired HIV from their mothers. In 2005, 660 000 children under the age of 15 were in need of immediate ART, representing more than 10% of unmet global need. Nine out of ten children needing treatment live in sub-Saharan Africa.

While an estimated 36 000 injecting drug users (IDUs) were receiving ART by the end of 2005, more than 80% (30 000) of these are in Brazil. The remaining 6000 patients were distributed among 45 other countries. These figures suggest a large unmet need, particularly in Eastern Europe and Central Asia, where IDUs represent 70% of HIV cases but just 24% of patients currently on treatment.

"Misinformation about the disease and stigma against people living with HIV still hamper prevention, care and treatment efforts everywhere," said Dr Peter Piot, UNAIDS Executive Director. "If we are to get ahead of the AIDS epidemic, we must tackle stigma, ensure that the available funds are spent effectively to scale-up HIV prevention, care and treatment programmes, and mobilize more resources."

Moving Toward Universal Access

While important advances in HIV treatment access have been achieved in the past two years, the report also acknowledges that, despite the efforts of many partners and significant funding from a number of

donors, the "3 by 5" strategy fell short of its ambitions. Obstacles to scaling up HIV treatment and prevention highlighted in the report include poorly harmonized partnerships; constraints on the procurement and supply of drugs, diagnostics and other commodities; strained human resources capacity and other critical weaknesses in health systems; difficulties in ensuring equitable access; and lack of standardized systems for the management of programmes and monitoring progress.

“The past two years have provided a wealth of experience and information on which we must now continue to build,” said Kevin De Cock, Director, HIV/AIDS Department at the World Health Organization. “We intend to utilize this knowledge to focus future efforts on overcoming persistent challenges and obstacles. It is particularly important that scaling-up HIV prevention, treatment and care services contributes to strengthening of health systems overall.”

A number of lessons learned in treatment scale-up efforts and outlined in the new report provide a valuable roadmap for efforts to achieve universal access to treatment. Among these are:

- The positive impact of targets in creating and sustaining momentum for action and in increasing accountability among stakeholders. A key element of the “3 by 5” strategy was developing bold country-level targets that encouraged national governments to expand capacity beyond what was previously considered possible. Moving forward, targets for treatment must be complemented by achievable targets for other elements of a comprehensive response to AIDS, including prevention and mitigating impact.
- The need to strengthen health systems. Building universal access to HIV treatment will require significant ongoing efforts to re-build, reinforce and expand under-staffed and under-funded health care systems that are already severely challenged in many countries.
- Promoting a 'public health approach' to health care delivery that emphasizes service decentralization, community mobilisation and education, team-based approaches and the delegation of routine tasks to trained nurses and health workers. The approach also promotes use of mechanisms to ensure the consistency and quality of supplies of drugs and diagnostics as well as the routine offer of voluntary testing and counselling to increase knowledge of HIV status in settings where there is high HIV prevalence.
- The ongoing need to intensify prevention efforts and to integrate prevention and treatment scale-up, using all effective approaches and paying particular attention to the needs of vulnerable groups. Epidemiological modelling consistently shows that more deaths can be averted with a comprehensive response including both prevention and treatment, than by focusing on treatment or prevention alone.
- The need for substantial increases in resources and sustainable financing. UNAIDS estimates that the gap between available resources and those needed is US$18 billion for the period 2005-2007, and that at least US$22 billion per year will be needed by 2008 to fund comprehensive national HIV prevention, treatment and care programmes.
- Long-term donor commitments are essential to ensuring sustainable treatment scale-up, as placing large numbers of people on ART is impractical for many countries without firm funding. The report encourages the use of innovative financing mechanisms to fund increased resources for AIDS. These include a proposal by France to introduce an airline solidarity contribution and the UK’s International Finance Facility, which aims to “front-load” additional funds leveraged from international capital markets to make them immediately available for sustainable investments that support the achievement of the Millennium Development Goals.

The new report emphasizes that WHO and UNAIDS will continue to build upon these lessons learned, as well as on the priorities, strategies and partnerships of “3 by 5" in accelerating the AIDS response. UNAIDS is currently facilitating the development of nationally agreed plans and targets to move towards universal access to HIV prevention, treatment, care and support. WHO's contribution to realizing the goal of universal access will be based on a set of priority interventions in the following five strategic directions, known to be able to significantly influence the epidemic in different epidemiological contexts:

- enabling people to know their HIV status through HIV testing and counselling;
- accelerating the scale-up of treatment and care;
- maximizing the health sector's contribution to HIV prevention;
- investing in strategic information to guide a more effective response; and
- strengthening and expanding health systems.

Remarks : The "3 by 5" aim to have 3 million people in low and middle income countries on antiretroviral therapy (ART) by the end of 2005.

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Healthy Relationships
an oversea training experience

Over the past two decades, HIV prevention activities have been focused on helping uninfected persons at high-risk of acquiring the disease through making change and maintain behaviours to keep them uninfected. In addition to the need for continuous prevention strategies aim at uninfected individuals, prevention efforts focus on HIV-positive populations is needed as every new infection involves an HIV-infected individual. HIV-infected people are living longer due to better treatment of antiretroviral therapy and prophylaxis for opportunistic infections and the emerging and transmission of drug resistant viruses. The need of them to maintain conducive behaviours has become prominent in preventing the spread of the disease.

I was nominated to attend a four-day training course on healthy relationships and three weeks attachment to community-based organisations (CBOs) in New York City in February this year. The title of the training was Healthy Relationships: A Small Group-level Intervention with People Living with HIV/AIDS. This no-cost training was part of Center for Disease Control and Prevention's (CDC) Diffusion of Effective Behavioral Interventions (DEBI) project. The collaborating agencies were the New York City Department of Health and Mental Hygiene and the Rochester Behavioral Intervention Training Center. Healthy Relationships was a five-session, small-group intervention for men and women living with HIV/AIDS. It was based on Social Cognitive Theory and focused on developing skills and building self-efficacy and positive expectations about new behaviours through modeling behaviours and practicing new skills. The intervention was not a disclosure intervention but was focused on building skills (decision-making and problem solving skills) to reduce stress in three life areas which included disclosure of HIV status to family and friends; disclosure to sex or needle sharing partners; and safer sexual behaviours. Twenty trainees from different CBOs mainly from New York took part in the training. Exercises on performance of real situation were used. Comments and feedback were encouraged from observers (on-looker trainees) which provided very useful information for trainers and trainees.

Other than the four-day training, I visited eight CBOs located in New York City, New Jersey and Bronx. From there, I had learnt their programmatic efforts with Healthy Relationships, Prevention Case Management (PCM), and / or Partnerships for Health, Community Promise; starting from the get go, development to implementation, evaluation to revisions - the hows, whys, whens, wheres, etc.. The coordinators were eager to share with me of their program's experiences, the good, the bad, and the challenges they had faced.

The experiences gained during the CBOs' visits were the most treasured part of the training programme. It had tremendously expanded my communication network. It had also greatly broadened my view and perspective on the HIV prevention programming. Most importantly, it had strengthened my mind on ways we could put in our efforts and complement with each other in fighting against the disease.

My appreciation goes to 1) Mr Walter Chow (Health Advisor of CDC) and his colleagues who had kindly arranged this remarkable programme for me. 2) Dr KH Wong (Consultant SPP), Ms Victoria Kwong (SNO, SPP) and those caring colleagues who had given me incredible support and backup before and during my stay in New York City. Without them, this trip would not be so beautiful, fruitful and wonderful!!!

Healthy Relationships Training

International AIDS Conference

The XVI International AIDS Conference will be held in Toronto Canada from 13 to 18 August 2006. The theme of the Conference is "Time to Deliver". It emphasizes the urgency of effective HIV prevention, care and treatment all over the world, as well as the need for increased accountability of all stakeholders. For the interested parties, please visit www.aids2006.org for more information.

Dr Albert Au

Lions Red Ribbon Fellows from Xinjiang

All Lions Red Ribbon Fellows of 2005 have completed their training in Hong Kong (HK). The last two Red Ribbon Fellows (Dr. Liu Wei and Dr. Chen Zhi-sheng) visited HK from 25 April 2006 to 6 May 2006. They had delayed their visit scheduled in 2005 until this year as they have taken up the responsibility to conduct HIV surveillance work in their home province in Xinjiang. Both treasured this opportunity to share their experiences with HIV workers in HK.

Dr. Liu and Dr. Chen work as epidemiologists in the Centre for Disease Control (CDC) of Ili Kazakh Autonomous Prefecture in Xinjiang province. They are the first batch of Red Ribbon Fellows from Xinjiang. Both have worked in HIV prevention in their home province since 1998 when the problem of HIV/ AIDS started to surface in that area. Over the years, they have participated in various surveillance, prevention and publicity works.

During their stay in HK, they visited the Red Ribbon Centre, the Integrated Treatment Centre and the Voluntary Counseling and Testing Service of the Special Preventive Programme of the Department of Health. They also visited methadone clinic, social hygiene clinic and various non-governmental organizations (NGOs), e.g. AIDS Concern, Hong Kong AIDS Foundation, Hong Kong Society for the Aid and Rehabilitation of Drug Abusers, etc. Besides, they had the chance to join a training activity of the Phoenix Project - a harm reduction outreach project targeting at drug users. They were impressed by the resources that the Government has devoted in the fight against AIDS, especially in the clinical care and support given to people living with HIV/ AIDS. They also recognized the great contribution of NGOs in our prevention efforts.

They conducted a seminar to share the HIV situation in Xinjiang, especially Ili Kazakh Autonomous Prefecture, and the responses to the epidemic in their place. In contrast to the situation in HK, intravenous drug use is the most common route of transmission while sexual route constituted only a small proportion of the cases in Xinjiang. In combating HIV/ AIDS, many education and prevention programmes have already been conducted. Training was also provided to HIV workers. Behavioral intervention targeting patients with sexually transmitted infections, promotion of safer sex and prevention of mother-to-child transmission programme have been launched in recent years. In addressing the culprit of the epidemic, needle exchange programme has been set up. Since the end of 2005, the first methadone clinic has started operation in Ili Kazakh Autonomous Prefecture. They told us that efforts to escalate the programme will continue in 2006. Both have gained deeper understanding in the model of methadone treatment programme in HK during this trip.

Up to April 2006, a total of 39 Lions Red Ribbon Fellows have completed their fellowship in HK.

Dr. Liu Wei, Lions Red Ribbon Fellow from Xinjiang (right) and Dr. Wong Ka Hing, Consultant of Special Preventive Programme (left)

(Dr. Krystal Lee)

Consultancy visit by Dr. Tim Brown

18–21 April 2006

As part of the effort to draw up the coming 5-year strategy for the Hong Kong AIDS programme, an estimation and projection project of the Hong Kong HIV situation has been initiated since last summer. We were grateful to have invited Dr. Tim BROWN of East West Center at Honolulu as the advisor to the project. Under his guidance, colleagues of the Special Preventive Programme then worked on collecting, digesting and assimilating the relevant data. The finale to the project was a consultancy visit by Dr. BROWN to Hong Kong where he would analyse the local data in depth and to generate an informed estimation and projection of the HIV situation in Hong Kong into the near future.

The week of the Buddhist Birthday this year marked one of the busiest weeks for our team, and perhaps so for Dr. BROWN! In mere four days, Dr. BROWN and our team reviewed the local data, generated the preliminary estimation and projection result and key recommendations to our local strategy, participated in 6 meetings with different workers in the field (four with community groups, one with members of HK Advisory Council on AIDS and AIDS Trust Fund) and conducted three training activities! We also held one out-door activity: observed the commercial sex activities in Yuen Long district, Mongkok and Yaumatei area and exchanged views with local workers.

During the week, there were two occasions I found most stirring. The first one was the time when we generated the projection curve showing HIV prevalence in MSM into 2020. After we input all local data into the Asian Epidemic Model, my colleagues and I were indeed overwhelmed by firstly, the rapid growth of the epidemic that just seems impossible in a low prevalence area like Hong Kong; and secondly, how well the curve matches with the observed data in terms of timing and rate of growth. Nonetheless, the message inferred from the projection since then has become the most important piece of message that people involved in the Hong Kong AIDS programme should know - act now.

The second occasion was the meeting we had with the local MSM community the night before Dr. Brown left Hong Kong. To our surprise, we were able to call up about 20 individuals from the gay community in just a short notice and we once again sent the message on the seriousness of 'their' epidemic and urge them to act fast. In fact, we are going to feel helpless without their participation because the only effective approach has to be from the community themselves. The meeting turned out to be an impressive one that lasted for three hours to almost midnight. Dr. Brown presented the result concisely and provided them with clear explanations. It seemed that members have registered the issue in their memory and the meeting hopefully has bought the 'community engagement' process a big step forward.

Surely, the process of making best use of data and using it to advocate for appropriate response did not end with Dr. Brown's visit. On the contrary, his visit has left us with a huge amount of work to be accomplished by the collaborative effort of the Hong Kong community, to curb the HIV epidemic on the march.

As a physicist in his early days, Dr. Brown not only works with the numbers and formulas but he also works as a teacher, an epidemiologist and an advocate. During his visit, I am sure those who have met him would agree that he has taught us how to understand the HIV epidemic, made best use of

Dr. Tim Brown, seminar Fellow from Hawaii (left) and Prof. CN Chen, ACA Chairman (right) held an Open Lechure on AIDS in Hong Kong

available data and to advocate what one truly believes that is beneficial to the public health. Almost ninety-percent of the participants in the various training activities found the programme excellent or good, and many suggested to more frequent training activities from international experts.

Finally, I'd like to express our heartiest thanks to Dr. Brown again, who has indeed let me and my colleagues to appreciate and understand epidemiology and advocacy, and we are indebted to all he has done for Hong Kong. We wish him in good health always.

Remarks :

Dr. BROWN participated in the external review of the Hong Kong AIDS programme in 1998 as an external consultant, and was the special advisor to the AIDS Prevention and Care Committee (2002-2005). He is the Special Advisor of the current Scientific Committee on AIDS and STIs formed in 2005. Dr Brown is the senior fellow of Population and Health studies at the East West Center in Honolulu. He has accumulated extensive research and consultancy experience in HIV epidemiology in many Asian countries. He is currently a member of the UNAIDS Reference Group on Estimates, Modelling and Projection and the Mapping the AIDS Pandemic Network. He is also one of the developers of the Asian Epidemic Mode. His latest research project 'Integrated Analysis and Advocacy' was 'an outgrowth of a growing sense of frustration' when he, and other colleagues, continued to witness growing HIV epidemics despite substantial knowledge of what constitutes effective interventions.

A seminar on HIV situation in Hong Kong was conducted by Dr. Tim Brown

(MSF)

Lacking AIDS second-line treatment options: Kaletra as an example

As of World AIDS Day 2005, an estimated more than 1 million people in developing countries have access to antiretroviral (ARV) therapy. However, patients who have been taking first-line ARVs for a while will soon face a cruel reality: the lack of second-line medicines. As more and more patients have access to ARV therapy (ART), there will inevitably be a growing number who face drug resistance and the need for second line ARVs will soon follow.

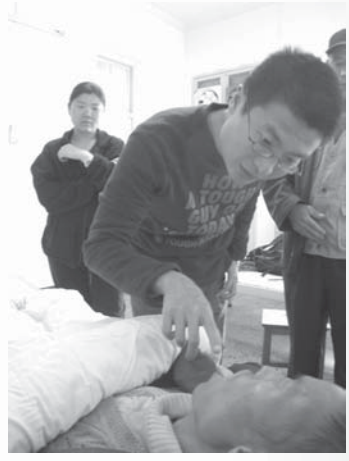
Medecins Sans Frontieres (MSF) is deeply concerned that a cornerstone of second-line ART - the new heat-stable version of lopinavir/ritonavir (LPV/r), is not available in developing countries. The situation is especially dire in middle-income countries like China.

An Essential Medicine for Second-Line Treatment

Currently MSF provides ARV treatment to nearly 70,000 patients in 51 projects across 31 countries. In 2005, approximately 6 percent of MSF patients who had been on treatment for three years were on second-line drugs, and in one MSF programme in South Africa, after four years of treatment, 16% of patients needed a new combination. These data underline the acute and growing need for access to newer, field-adapted second-line drugs.

With other members of the AIDS community, MSF launched an international campaign in March 2006 calling on Abbott Laboratories, the Chicago-based drug company, to make a new formulation of LPV/r, marketed as Kaletra, available for patients in developing countries.

LPV/r has been recognized as an essential medicine by the WHO, as it is the only co-formulation that consists of a protease inhibitor (lopinavir) and booster (ritonavir) in the same pill. The WHO includes LPV/r in its revised recommendations[2] as part of second-line therapy once first-line treatment failure has occurred. Abbott Laboratories has been marketing the old formulation of LPV/r since 2000. But the old version of LPV/r has some serious drawbacks, as it



Hong Kong Doctor Arthur Pang once worked in HIV/AIDS treatment and care project in Xiangfan, Hubei Province

requires refrigeration, comes with a high pill burden of six capsules per day and needs to be taken with food. The US Food and Drug Administration (FDA) approved the improved new version of LPV/r in October 2005: storage without refrigeration, lower pill count [down to four per day], and no dietary restrictions.

New and improved Kaletra: Only in the US... But What About the Rest of the World?

No other boosted protease inhibitors are practical to use in the hot climates of many developing countries, where refrigeration is not readily available. If made accessible and affordable, the new and improved version of LPV/r could offer major benefits to patients across the developing world.

Yet, since its approval given by the US FDA, new LPV/r is available in the US, but not in any developing countries.

In April 2006, HIV/AIDS researchers and clinicians, investor groups, treatment advocates, and policy-makers from around the world co-signed a letter with MSF to Abbott's CEO calling for the company to take immediate steps to make heat-stable LPV/r available to patients in developing countries. Under pressure, Abbott agreed to fulfill an MSF's order for 400 patients in 9 countries.

Several weeks later, Abbott announced that it would charge $500 (down from $10,000 in the United States) per patient per year for the new LPV/r in African and least-developed countries; however, no one can buy the medicine yet because the company has not taken steps to make it available in any of these countries except South Africa. In addition, Abbott has not published a price for middle-income countries such as China, Thailand or India.

China is among those middle-income countries which are not eligible for the reduced price of the new formulation of LPV/r. In fact, the problem is even worse: there is no LPV/r available in China, neither the new nor the old formulation, because Abbott has chosen not to market the drug there.

Chinese patients: don't deserve Kaletra?

In China, 20,453 AIDS patients are currently receiving ART. According to one study by the Chinese Academy of Medical Sciences in 2004, 27-31% of patients were already resistant to at least one ARV drug.[1] When the first-line ARV drugs no longer work, these patients will need to switch onto second-line drugs.

Since 2003, Medecins Sans Frontieres (MSF) has run two HIV/AIDS treatment and care projects in Nanning, Guangxi Province and Xiangfan, Hubei Province. At present, about 400 patients are on ART, out of 800 total patients followed. MSF expects 10 to 15 of them will require second-line drugs by the end of this year, with the numbers increasing over time. From a medical point of view, one of the best options for treatment would be LPV/r.

The old version of LPV/r has been registered since 2003, but Abbott has not marketed the drug, despite the fact that it has a patent monopoly on LPV in China until 2016. That means the drug is, practically speaking, not available to patients. By neglecting the patients of China, Abbott is failing to fulfill its commitment to broadening "access by providing HIV care products at a loss" to the "programmes that need them most".

Two years back in June 2004, in a meeting with Abbott China, MSF was informed that the old formulation of LPV/r would be marketed in October in the same year. Despite repeated requests from MSF over the past two years, as of May 2006, the drug has still not been put on the market.

In the Long Run, Alternative Suppliers Will Be Critical

The current inability to procure heat-stable LPV/r - and in China, any LPV/r at all -- underscores the ongoing challenge of access to medicines in developing countries. Generic competition has led to the dramatic decrease in price and increase in availability of first-generation ARV medicines. However prices of newer drugs remain much higher, as all new drugs may be subjected to at least 20 years of patent protection practically everywhere except in least developed countries since the full implementation of the WTO TRIPS (Trade-related Aspects of Intelectual Property Rights) Agreement in 2005 in India and other developing countries. The case of the new formulation of LPV/r which costs as much as $10,000 per patient per year in the United States - the only place it is currently available - illustrates the danger of having only one source for a life-prolonging medicine. If access to needed drugs depends on the marketing policies of pharmaceutical companies, then the lives of millions of people with HIV/AIDS remain at risk.

[1] Zhang Fujie, "Delivering antiretroviral therapy in China: progress and challenges." Presentation made on 9 May 2005.